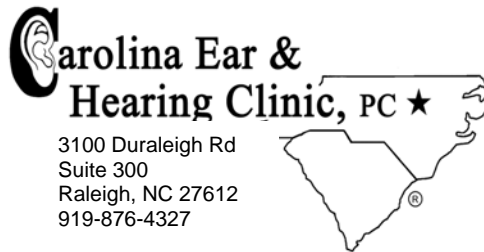


Carolina Ear and Hearing Clinic New Patient Packet

New Patients: Please print out, complete, and bring to your scheduled appointment.

Contents of Packet

- Patient Welcome Letter
- Directions to Carolina Ear and Hearing Clinic
- Patient Registration Form
- Medical Questionnaire
- Financial Policy
- Acknowledgement of Receipt of Notice of Privacy Practices



Dear Patient:

Welcome to our practice! Carolina Ear and Hearing Clinic is dedicated to providing our patients with the best otologic care available. Thank you for choosing us for your medical needs. Enclosed please find New Patient Information and release forms you will need to complete prior to your visit, along with some additional information about our practice.

Please carefully read and fill out these forms, and present them to the receptionist, along with your insurance card when you arrive for your appointment. For your first visit, kindly arrive 15 minutes early to allow time for your information to be processed. Please allow at least 2 hours for your visit. Physician referrals are required for office visits- regardless of your insurance carrier -since we are a specialty practice. Other items you will need for your appointment are:

- The insurance authorization number from your Primary Care Physician-if you are a member of an HMO or POS plan. (You will need to obtain this prior to your appointment time)
- If you have a co-payment, or have not yet met your deductible, please be prepared to pay this at the time of service.
- If your referring physician has performed x-rays and/or other tests or studies, please bring the films and test results with you.
- Any medical records pertinent to why you are being seen by our physicians
- should be requested from your current physicians prior to your appointment. This information may be faxed to (919) 876-6800.
- A list of your current medications and drug allergies

Appointment Policy:

Please be aware that we are a multi-service practice. We have multiple providers performing audiological exams and testing under the doctor's supervision. These services do not interfere with the doctor's regular schedule or with the time reserved for you. In most cases, the doctors are able to see you at the time of your scheduled appointment. However, unexpected prolonged patient procedures may delay the daily schedule. We appreciate your understanding in these situations. We do all we can to keep prompt appointment schedules and provide you with the best medical care. The receptionists will inform you if a long delay occurs. You may reschedule if waiting is a problem. Emergency surgical procedures may make it necessary to cancel appointed office hours. We acknowledge how inconvenient this may be for you and will do our best to make your rescheduled appointment meet your needs. We regret having cancellations ever, and do our best to minimize them.

We understand that from time to time a scheduled appointment may need to be changed. Due to the nature of our specialized practice we ask that you please allow our office at least a 24 hour notice for cancellations or rescheduled appointments. Failure to do so will result in a fee of \$50.00.

Thank you for choosing Carolina Ear and Hearing Clinic. Please feel free to contact us at anytime with your questions or concerns.

Sincerely,

Directions to Carolina Ear and Hearing Clinic

From Greensboro, Charlotte, Chapel Hill

Take I-40 East

Exit #289 (Wade Ave.)

Take first exit off of Wade Ave. which is Edwards Mill Rd.

Turn Left onto Edwards Mill Rd. and follow it until you get to the stop light at Duraleigh Rd.

You will see Raleigh Medical Center diagonally across from you – go through this light and take the first right into the entrance of our parking area.

From Apex

Take US 1/64 to 440/Inner Beltline (US 1/64 will run into 440/Inner Beltline)

Take Exit 5 –Lake Boone Trail

Turn right onto Lake Bone Trail

At the stop light past Rex hospital, turn right onto Blue Ridge Rd. (you will be going along side Rex)

Go straight through the second stop light (at this light, Blue Ridge Rd turns into Duraleigh Rd.)

We are the next brick and glass building on your right – the parking lot entrance has a small blue sign that says “3100 Duraleigh” on it.

From Wilmington

Take I-40 West to exit 301 (outer beltline)

Take Exit 5 – Lake Boone Trail

Turn right onto Lake Bone Trail

At the stop light past Rex hospital, turn right onto Blue Ridge Rd. (you will be going along side Rex)

Go straight through the second stop light (at this light, Blue Ridge Rd turns into Duraleigh Rd.)

We are the next brick and glass building on your right – the parking lot entrance has a small blue sign that says “3100 Duraleigh” on it.

From Fayetteville

Take I-95 North to I-40 West

Take I-40 West to exit 301 (outer beltline)

Take Exit 5 – Lake Boone Trail

Turn right onto Lake Bone Trail

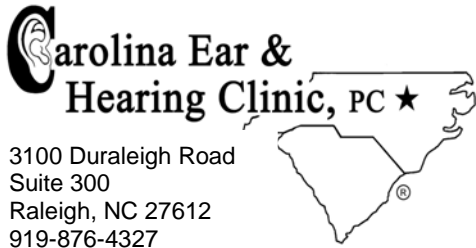
At the stop light past Rex Hospital, turn right onto Blue Ridge Rd. (you will be going along side Rex)

Go straight through the second stop light (at this light, Blue Ridge Rd turns into Duraleigh Rd.)

We are the next brick and glass building on your right – the parking lot entrance has a small blue sign that says “3100 Duraleigh” on it.

Patient Registration Form

Today's date:		Updated by/date:			
PATIENT INFORMATION					
Last name:		First:		Middle:	
				<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	
Social Security #		Birth date: / /		Age:	
				Sex: <input type="checkbox"/> F <input type="checkbox"/> M	
Status: Single / Married / Divorced / Separated / Widowed / Student			E-mail address:		
Street address:			P.O. Box:		
City:		State:		ZIP Code:	
Home phone: () Please include area code		Cell Phone: () Please include area code		Work phone: () Please include area code	
Referring Physician Name, Address and Phone:					
If you were not referred by a Physician , How did you hear about us? Family / Yellow Pages / Internet / Patient / Other _____					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Is this patient covered by insurance?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Please provide Primary insurance information					
Insurance co. Name		Subscriber's name:		SS #:	
				Birth date: / /	
Group #:		Policy #:		Co-payment \$	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (explain)					
Please provide Secondary insurance information					
Insurance co. Name:		Subscribers name:		SS #:	
				Birth date: / /	
Policy #:		Group #:		Co-payment \$	
Patients relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (explain)					
Responsible party name and address: (If patient is under 18)					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone #.: Please include area code	Work phone #.: Please include area code	
			()	()	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Carolina Ear and Hearing Clinic, P.C. or insurance company to release any information required to process my claims.					
Patient/Resp. party signature _____		Print name _____			
Date _____					



Medical Questionnaire

Patient Name: _____

Reviewed: _____, M.D.

Date: _____

Patient Name: _____ Date: _____
Occupation: _____ If retired, previous occupation: _____

1. Reason for today's visit: _____

2. Please list your other physicians and their specialties:

3. How would you rate your general health? _____

4. Have you had any of the following? (Please circle):

- | | | |
|------------------------------|-------------------------|----------------------------------|
| Headache | Ulcers/Stomach Problems | Sinus/Nasal Disease |
| Stroke | Gallbladder Disease | Hoarseness/Voice Problems |
| Meningitis/Encephalitis | Bowel Irregularity | Difficulty Swallowing |
| Other Nervous System Disease | Hepatitis/Liver Disease | Facial Pain |
| Psychiatric Disorder | Kidney/Urinary Disease | Asthma/Lung Disease |
| Glaucoma/Eye Disease | Prostate Problems | Allergies/Hay Fever |
| Heart Disease | Thyroid Disease | Radiation Therapy |
| High Blood Pressure | Diabetes | Skin Problems |
| Fainting Spells | Arthritis/Gout | Autoimmune Disease (Lupus, etc.) |
| Peripheral Vascular Disease | Cancer/Tumors | Weight Loss |
| Anemia/Easy Bleeding | Other: _____ | |
| Muscle/Skeletal Problems | | |

5. As a child, did you have any of the following? (Please circle):

- | | |
|-------------|------------------------------|
| Measles | Ear Infections |
| Mumps | Other Significant Illnesses: |
| Chicken Pox | _____ |
| | _____ |

6. Previous operations (please list type and date):

Ear: _____
Neurosurgical: _____
Other: _____
Any difficulty with anesthesia? _____ Any bleeding problems after surgery? _____

7. Describe any previous injuries or accidents:

To the ear and head: _____

Other: _____

Noise Exposure: _____

Patient Name: _____
Date: _____

8. List any diseases that run in your family history:

Ear: _____
Brain/Nervous System: _____
Bleeding Disorders: _____
Other: _____

9. Social habits::

Smoking? Packs daily _____ How long? _____ When did you stop? _____
Caffeine? (Coffee, tea, cola): _____
Alcohol? (Type/Amount): _____
Diet? Regular: _____ Special: _____
Exercise? Type: _____ How Often? _____

10. Are you disabled in any way? _____
Do you have any birth defects? _____

Have you had alternative medical care (acupuncture, chiropractic, naturopath, etc.)? _____

Record of Medications

A. Allergies to any medications? _____
Please list medication and what reaction was experienced: _____

B. Current medications (include aspirin, vitamins, over-the-counter medications, and ear drops):
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
(Continue on separate page if necessary)

C. Have you taken Cortisone in the past year? _____ If yes, please explain usage: _____

D. Please list any hazardous chemicals you come into contact with at work: _____

E. Have you had any of the following:
1. Prolonged use of antibiotics given by vein (IV)? _____
2. Chemotherapy agents for cancer? _____
3. High doses of aspirin (more than 8 per day)? _____
4. Quinine for malaria? _____
5. Diuretics (water pills)? _____

If yes to any of the above, please explain:

Carolina Ear and Hearing Clinic Financial Policy

It is the goal of Carolina Ear and Hearing Clinic to provide you with the finest of medical care available at a cost that is both fair and reasonable. Your understanding of our financial policy is essential.

The following is our Financial Policy, which we require that you read and sign prior to treatment:

- Self-pay patients are expected to pay for services received in full at the time of service. Any financial arrangements must be made before you see the physician.
 - We cannot file your insurance if you do not have a copy of your insurance card or the necessary insurance information. Without a copy of your insurance card, we must have the insurance company's name, phone number to verify benefits, policyholder's name, date of birth, and insurance identification number. Without this information, your account will be treated as self pay. (See above)
 - If your health plan requires a referral or authorization from your primary care physician, we will need to receive the authorization before you see our physician. If we have not received an authorization prior to your arrival at our office, we have a telephone available in our waiting room for you to call your primary care physician or health plan to get it. If you are unable to obtain the referral at that time, you can sign a medical wavier and pay us directly for the services we provide you. We will refund you when we receive the proper authorization for those services.
 - As a courtesy to you, we will file charges with your insurance company. Charges not paid by your insurance company within 90 days will become due and payable by you unless you have Medicare or Medicaid.
 - All co-payment, co-insurance, and deductible amounts are due at the time of service and prior to your scheduled surgery. We accept cash, check, Visa, MasterCard, and American Express.
 - The responsibility for payment of services rendered to dependent children whose parents are divorced rests with the parent seeking treatment. Any court ordered responsibility judgment must be determined between the individuals involved and cannot be considered by this office.
 - In the event your health insurance determines a service to be "not covered", you will be responsible for payment. We try to inform patients when services may not be covered; however, it is the patient's responsibility to understand his/her policy limitations.
 - In order for us to accept and file Medicaid we must have a CURRENT Medicaid card on file for each visit. Carolina Access requires an authorization from your Primary care Physician. Without this information you will be considered self-pay and Medicaid will allow us to collect from you at the time services are rendered.
 - We will bill for workers compensation services that have been pre-authorized by your employer or workers comp insurance carrier. You will receive a monthly statement from this office to keep you informed. After 90 days, these charges become your responsibility.
 - Copying medical records: You will need to request in writing and pay a reasonable copying fee if you want to have copies of your medical records. Please allow a minimum of two weeks for copies to be ready.
 - A \$25 service charge will be applied to your account for any returned check. If a check has been returned, we will only accept cash, Visa, MasterCard, and American Express.
- We understand that from time to time cancellations and rescheduling appointments occur. Due to the nature of our specialized practice we ask that you please allow our office at least 24 hour notice for cancellations and to reschedule appointments. Failure to do so will result in a no show fee of \$50.00.

Please be aware that any unpaid balance over 90 days is subject to intensive collection procedures.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force.

Patient's name: _____

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: _____

Leave a message on my answering machine/voicemail: YES NO
Speak with a family member in my home about my care: YES NO
Speak with family member calling our office concerning my care: YES NO

Signature below is only an acknowledgement that you have received this Notice of Privacy Practices:

Signature: _____

Date: _____

For Official Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

Prepared By: _____

Signature: _____

Date: _____